

ADVANCE PAY CERTIFICATION/AUTHORIZATION

Privacy Act Statement

AUTHORITY: 37 U.S.C. 1006 et seq; E.O. 9397 November 1943 (SSN).

PRINCIPAL PURPOSES: To document a member's request for, and subsequent authorization of, an advance of pay to meet extraordinary expenses incident to a PCS move. It is also used to inform the member of the purposes and restrictions of such advances, and to establish repayment schedules.

ROUTINE USES: Information collected on this form becomes part of the Joint Uniform Military Pay System (JUMPS), and Reserve component pay systems and is subject to all of the routine disclosures which are more fully described in Service regulations. Routine recipients of JUMPS disclosures include, but are not limited to, Red Cross, State and local government for tax and welfare purposes.

DISCLOSURE: Voluntary; however, failure to provide the SSN will result in denial of payment since it is used to identify you for pay purposes.

PART I. REQUEST

1. NAME (Last, First, Middle Initial)		2. SOCIAL SECURITY NO.		3. GRADE	
4. I REQUEST:		5. I REQUEST A REPAYMENT SCHEDULE OF:		6. I REQUEST PAYMENT OF THE ADVANCE PAY:	
a. ONE MONTH ADVANCE PAY (See Policy Guidance on reverse.)		a. 12 MONTHS OR LESS (Specify number of months)		a. WITHIN 30 DAYS OF PCS OR 60 DAYS AFTER REPORTING TO MY NEXT PDS.	
b. MORE THAN 1 MONTH BUT LESS THAN 3 MONTHS BASIC PAY LESS DEDUCTIONS (Parts II and V must be completed.) (Specify amount)		b. 13 - 24 MONTHS (Parts III and V must be completed regardless of pay grade. NOTE: Repayment schedule cannot exceed member's date of separation.) (Specify number of months)		b. 31 - 90 DAYS BEFORE MY PCS (Parts II and V must be completed.)	
\$				c. 61 - 180 DAYS AFTER ARRIVAL AT MY PDS (Parts II and V must be completed.)	

PART II. CERTIFICATION OF EXPENSES (Actual or Anticipated) (Continue in Item 23 on reverse if necessary.)

7. EXPENSE	8. AMOUNT	10. EXPLANATION OF THE CIRCUMSTANCES WHERE GREATER-THAN-NORMAL EXPENSES MIGHT BE INCURRED OR CIRCUMSTANCES REQUIRING AN EARLY OR LATE PAYMENT OF ADVANCE PAY (Up to 90 days before and 180 days after).
a.	\$	
b.	\$	
c.	\$	
d.	\$	
e.	\$	
f.	\$	
9. TOTAL	\$	

PART III. JUSTIFICATION FOR MORE THAN 12 MONTHS PAYBACK

(Justification must demonstrate that severe hardship would result if the advance is paid back in 12 months)

11. NO. OF DEPENDENTS	12. LIST SPECIFICS OF YOUR FINANCIAL SITUATION, INCLUDING OUTSTANDING DEBTS AND MONTHLY PAYMENT AMOUNTS THAT INDICATE A SEVERE HARDSHIP IN REPAYING THE ADVANCE IN THE NORMAL 12-MONTH TIME PERIOD (Continue in Item 23 on reverse if necessary.)
-----------------------	---

PART IV. MEMBER CERTIFICATION

Penalty: The penalty for willfully making a false claim/statement is *a maximum of \$10,000 or maximum imprisonment of five years, or both (U.S. Code, Title 18, Section 287).*

If I am separated prior to my ETS, I consent to withholding from current pay, final pay, or any other money due me to satisfy this indebtedness. I further consent to such withholding at a rate sufficient to satisfy this indebtedness no later than my separation, and understand that this could result in the withholding of 100% of any current pay, final pay, or other money due me.

I have read and understood the policy on advance pay incident to a PCS contained on the reverse of this form. I hereby certify that the intended use of these funds meets the stated purpose. I have attached one copy of my PCS orders or assignment notification.

13. SIGNATURE	14. DATE (YYMMDD)
---------------	-------------------

PART V. APPROVAL OF MEMBER'S COMMANDER

15. I HEREBY APPROVE THIS REQUEST FOR ADVANCE PAY OF:		16. WITH LIQUIDATION OVER:		17. AND PAYMENT OF THIS ADVANCE:	
a. ONE MONTH BASIC PAY LESS DEDUCTIONS		a. 12 MONTHS OR LESS (Specify number of months)		a. WITHIN 30 DAYS OF PCS OR 60 DAYS AFTER REPORTING AT PDS	
b. AN AMOUNT SPECIFIED NOT TO EXCEED 3 MONTHS BASIC PAY LESS DEDUCTIONS (Specify amount) \$		b. 13 - 24 MONTHS (Specify number of months)		b. NOT PRIOR TO _____ (date) WHICH IS 31 - 90 DAYS BEFORE PCS	
				c. 61 - 180 DAYS AFTER REPORTING TO NEW PDS	
18. APPROVING OFFICIAL NAME (Last, First, Middle Initial)		19. SIGNATURE OF OFFICIAL			
20. TITLE		21. GRADE		22. DATE (YYMMDD)	

23. REMARKS

POLICY GUIDANCE

The purpose of an advance of pay incident to PCS is to provide a Servicemember with funds to meet the extraordinary expenses of a Government-ordered relocation, per DODPM Part 4.

An advance of pay shall not be authorized for the specific out-of-pocket expenses covered by advances of other pays and entitlements if such advances are used. The Servicemember may be authorized an advance of pay to the extent that incurred or anticipated expenses exceed those covered by the following advances or reimbursements, or are outside the scope of those entitlements:

- a. Overseas station housing allowance;
- b. Servicemember and/or dependent travel allowances and per diem;
- c. Dislocation allowance;
- d. Basic allowance for quarters and/or variable housing allowance.

An advance of pay for a PCS move in the same geographic area of a Servicemember's prior duty station, or place from which ordered to active duty, is only authorized when the Servicemember moves his/her household effects at Government expense. Proof of HHG shipment is required before advance pay for PCS moves in the same geographic area is paid.

An advance is not intended to provide funds for such items as investments, vacations, or the purchase of consumer goods that are not the result of direct expenses resulting from the Servicemember's PCS orders. Except under extraordinary conditions, an advance pay must be repaid before an advance for a subsequent PCS may be paid.

Servicemembers should consult appropriate Service regulations concerning grade levels requiring Commander's approval of a PCS advance that does not exceed 1 month's pay.

AIR FORCE MEMBERS ONLY: E4/SRA and below must have Commander's approval for all PCS advance pay payments.

AUTHORIZATION TO START, STOP OR CHANGE AN ALLOTMENT

PRIVACY ACT STATEMENT

AUTHORITY: 37 U.S.C. Section 701, E.O. 9397.

PRINCIPAL PURPOSE: To permit starts, changes, or stops to allotments. To maintain a record of allotments and ensure starts, changes, and stops are in keeping with member's desires.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. Section 552a(b) of the Privacy Act, these records of information contained therein may specifically be disclosed outside the DoD as a routine use to the Federal Reserve banks to distribute payments made through the direct deposit system to financial organizations or their processing agents authorized by individuals to receive and deposit payments in their accounts. It may also be disclosed to the Treasury Department, Internal Revenue Service, Social Security Administration, Department of Veterans Affairs, Federal, state and local agencies for civil or criminal law enforcement. In addition it can be released for any of the blanket routine uses published at the beginning of the DFAS compilation of system of record notices.

DISCLOSURE: Voluntary; however, failure to provide the requested information as well as the Social Security number may result in the member not being able to start, change, or stop allotments.

TO BE COMPLETED BY ALLOTTER

1. BRANCH OF SERVICE (<i>X one</i>) <input type="checkbox"/> AIR FORCE <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> ARMY <input type="checkbox"/> NAVY		2. NAME OF ALLOTTER (<i>Last, First, Middle Initial</i>) (Print or type)		3. SSN		4. PAY GRADE	
5. ADDRESS OF ALLOTTER (<i>Street or Box Number, City, State, ZIP Code</i>)				6. DAYTIME TELEPHONE NUMBER (<i>Include Area Code</i>)		7. EFFECTIVE DATE (<i>YYYYMM</i>)	
8. MONTHLY AMOUNT OF ALLOTMENT \$				9. NAME OF ALLOTTEE (<i>First, Middle Initial, Last</i>)		10. ALLOTMENT ACTION (<i>X one</i>) <input type="checkbox"/> START <input type="checkbox"/> STOP <input type="checkbox"/> CHANGE	
11. TERM IN MONTHS				12. CREDIT LINE (<i>If applicable</i>)			
13. ALLOTMENT CLASS AUTHORIZED (<i>X one</i>) <input type="checkbox"/> C - CHARITY/CFC <input type="checkbox"/> D - DISCRETIONARY ALLOTMENTS (<i>Includes dependent support, payment to financial institution, insurance, repayment of home loan, rent, etc. (Notes 1 and 2)</i>) <input type="checkbox"/> F - CHARITY - EMERGENCY/ASSISTANCE FUND CONTRIBUTION <input type="checkbox"/> L - REPAYMENT OF LOAN TO SERVICE ORGANIZATION (<i>Red Cross, Relief Society, etc. - Navy and Marine Corps only</i>) <input type="checkbox"/> N - NSLI OR USGLI INSURANCE PREMIUM <input type="checkbox"/> T - PAYMENT OF DEBTS TO U.S., DELINQUENT STATE OR LOCAL INCOME/EMPLOYMENT TAXES <input type="checkbox"/> - OTHER (<i>Specify</i>)				14. ALLOTTEE'S MAILING ADDRESS (<i>Street or Box Number, City, State, ZIP Code</i>)			
15. IF FOREIGN ADDRESS COMPLETE AS FOLLOWS (<i>Province, Country</i>)				16. REMARKS			
17. COMPANY CODE/FINANCIAL INSTITUTION/ROUTING TRANSIT NUMBER				18. ACCOUNT NUMBER/POLICY NUMBER			
19. TOTAL CLASS L AMOUNT \$				20. TOTAL CLASS T AMOUNT \$			
CHECKING SAVINGS				21. SIGNATURE OF ALLOTTER			
22. DATE (<i>YYYYMMDD</i>)				NOTE 1. Must be different address than allotter. Each dependent allotment must have a different credit line. Only one support allotment per dependent is allowed. NOTE 2. This is a voluntary allotment and can be to any payee you desire.			

STATEMENT OF UNDERSTANDING

I understand that this allotment is legal and that by **voluntarily** completing this form, I am responsible for:

- **Ensuring** that the information is correct;
- **Reviewing** my Leave and Earnings Statement to ensure the allotment stops, starts, or changes as directed including amount and payee;
- **Collecting** overpayments from the receiver (payee) of the allotment, if I do not change or stop the allotment after a loan is repaid;
- **Contacting** the receiver (payee) of the allotment, at my expense, to obtain monthly statements for my personal records.

I also understand that any problems once the allotment is delivered to the receiver (payee) are beyond the control of the Defense Finance and Accounting Service (DFAS) and that DFAS is only responsible for ensuring proper delivery of any voluntary allotment for the period directed. I further understand that pursuant to conditions listed in the DoD 7000.14-R, Volume 7A, changes can be made by DFAS to an allottee's name, address, or account number.

SAVINGS BOND ALLOTMENT AUTHORIZATION/ACTIVE DUTY OR RETIRED PAY

(Complete a separate form for each bond action.)

Privacy Act Statement

AUTHORITY: 37 U.S.C. 101 et seq; E.O. 9397, November 1943 (SSN).

PRINCIPAL PURPOSES: To permit starts, changes, or stops to bond allotments. To maintain a record of bond allotments and ensure starts, changes, and stops are in keeping with member's desires.

ROUTINE USES: Information may be disclosed to Congress; allottees; Secret Service; General Accounting Office; Federal, State, and local courts; U.S. Treasury; and to the Department of Justice in some cases for criminal prosecution, civil litigation, or investigative purposes.

DISCLOSURE: Voluntary; however, failure to provide the requested information as well as the SSN may result in the member not being able to start, change, or stop bond allotments. The furnishing of SSNs is required by the regulations governing savings bonds, Department of Treasury Circular, Public Debt Series No. 3-80 (31 CFR 353). The numbers are used to maintain ownership records of the bonds. Other information requested by this form is also required under the above regulations to establish the rights, authority and/or entitlement of the signers. Failure to furnish any of the required information may prevent completion of the transaction.

PART A. TO BE COMPLETED BY ALLOTTER

1. ALLOTTER'S NAME <i>(Last, First, Middle Initial)</i>				2. SOCIAL SECURITY NO.		3. GRADE <i>(AD only)</i>		
4. ALLOTMENT ACTION <i>(X one)</i>			5. EFFECTIVE DATE <i>(YYMM)</i>		6. AMOUNT TO BE ALLOTTED EACH MONTH \$		7. NUMBER OF MONTHS	
	a. Start		b. Stop		c. Change			
8. BOND DENOMINATION <i>(X one)</i>					10. OWNERSHIP CODES <i>(X one)</i>			
	a. \$100		b. \$200					
	c. \$500		d. \$1000					
9. MAIL BOND TO <i>(X one)</i>					4 Nonallotter Allotter None			
	A Owner		B Co-Owner/Beneficiary			5 Nonallotter None Allotter		
	C Third Party		D Hold in Safekeeping <i>(Only for Active Duty Bond Owners)</i>			6 Nonallotter Nonallotter None		
						7 Nonallotter None Nonallotter		
						8 Nonallotter None None		

PART B. BOND INSCRIPTION INFORMATION

11. BOND OWNER							
a. Name <i>(First, Middle Initial, Last)</i>						b. Social Security No.	
12. <i>(X one if applicable)</i>		CO-OWNER		BENEFICIARY			
a. Name <i>(First, Middle Initial, Last)</i>						b. Social Security No.	
13. THIRD PARTY <i>(If bond is mailed to a third party)</i>							
a. Name <i>(First, Middle Initial, Last)</i>				b. Mailing Address <i>(Street, Unit, etc.)</i>			
c. City		d. State		e. ZIP Code		f. Foreign City, Province, Country	
						g. Country Code	
14. I hereby authorize the foregoing allotment from my pay with the understanding that U.S. Savings Bonds will be issued as requested. This authorization is to remain in effect until cancelled by me in writing.							
a. Signature of Allotter						b. Date <i>(YYMMDD)</i>	

CAREER STATUS BONUS (CSB) ELECTION*(Read Instructions before completing form.)***PRIVACY ACT STATEMENT**

AUTHORITY: 37 U.S.C. 322; E.O. 9397; ASD(FMP) Memorandum dated February 2, 2001, Subject: Career Status Bonus Implementing Guidance.

PRINCIPAL PURPOSE: To record a member's eligibility and election to receive or not receive the Career Status Bonus with reduced retired pay (REDUX) and to adjust such retired pay according to the member's election.

ROUTINE USE(S): Information may be provided to the Internal Revenue Service to resolve matters relating to an individual's tax withholding; to the Federal Retirement Thrift Investment Board to establish eligibility for contributions to the Thrift Savings Plan for Uniformed Service personnel, and to the Department of Justice or state and local governments when a question of conflicting interest is raised concerning a member's declarations and election.

DISCLOSURE: Voluntary; however, failure to provide the requested information by the time instructed by the member's branch of Service could result in an irrevocable determination affecting the amount of retired pay the individual may later qualify to receive and disqualification for electing the Career Status Bonus.

SECTION I - PERSONAL IDENTIFICATION *(To be completed by Service Officials)*

1. NAME <i>(Last, First, Middle Initial)</i>		2. SSN	3. RANK/PAY GRADE/BRANCH OF SERVICE
4. DIEMS <i>(YYYYMMDD)</i>	5. DATE FOR DETERMINATION OF ACTIVE DUTY SERVICE COMPLETED <i>(YYYYMMDD)</i>		6. DATE OF NOTIFICATION <i>(YYYYMMDD)</i>

SECTION II - DETERMINATION OF ELIGIBILITY *(To be completed by Service Officials)*

7. You may be eligible to elect a Career Status Bonus (CSB). To be eligible, you must:

- (1) Be on active duty,
- (2) Complete 15 years of active duty service,
- (3) Have a DIEMS of August 1, 1986 or later, and
- (4) Qualify under Service regulations for retention to 20 years of active duty service.

Service records indicate that you are currently:

- ☐ Eligible to elect the Career Status Bonus.
- ☐ Not eligible to elect the Career Status Bonus.

REASON NOT ELIGIBLE:

8. DATE OF DETERMINATION <i>(YYYYMMDD)</i>	9. SERVICE AUTHENTICATING REPRESENTATIVE	
	a. PRINTED NAME <i>(Last, First, Middle Initial)</i>	b. SIGNATURE

SECTIONS III, IV, or V *(To be completed by Member and Witness as directed by Service)*

NOTE: Complete only one of these sections and then return it as instructed by your Service.

If not eligible, complete Section III only.

If eligible and you want to elect to receive the bonus, complete Section IV only.

If eligible and you do not want to receive the bonus, complete Section V only.

SECTION III - NOT CURRENTLY ELIGIBLE FOR CAREER STATUS BONUS

Complete this section only if **you are not currently eligible to elect the Career Status Bonus** and return the form as instructed by your Service.

10. I understand that I am not eligible for the Career Status Bonus at this time and that my ineligibility does not preclude my continued service to retirement if my Service so permits. I understand that I will not receive a bonus and I remain under the High-3 retirement system. I understand that my Service will notify me if I later become eligible to elect the bonus.

a. SIGNATURE	b. DATE SIGNED <i>(YYYYMMDD)</i>
---------------------	---

11. WITNESS		
a. PRINTED NAME <i>(Last, First, Middle Initial)</i>	b. RANK/PAY GRADE	c. POSITION/DUTY TITLE
d. ORGANIZATION	e. ORGANIZATIONAL ADDRESS	
f. SIGNATURE	g. DATE SIGNED <i>(YYYYMMDD)</i>	

SECTION IV - ELIGIBLE AND ELECTING TO RECEIVE THE CAREER STATUS BONUS

Complete this section only if you are eligible and **you desire to elect to receive the Career Status Bonus**. Then return the form as instructed by your Service.

12. I elect to receive the Career Status Bonus payment, with payments as indicated in block 12a below. I make this election upon my attainment of 15 years of active duty service and having been determined eligible for the bonus by my Service. I understand that once the election is effective it may not be revoked. My election is effective once received and accepted at the 15th year of service, or if later, the date received and determined acceptable by my Service, but no later than the date that is six months after being notified of my eligibility. I understand that if I receive the CSB in error, I must repay the full, before-tax bonus amount. I agree to remain on continuous active duty, subject to Service regulations, until I attain a minimum of 20 years of such service. If I fail to complete such service, I understand that I will be required to repay a share of the total (\$30,000) bonus payment in proportion to the amount of service I failed to complete compared to the additional service I agreed to serve. Any unpaid installments will be credited to my repayment. If I am separated prior to 20 years of service, I consent to withholding from current pay, final pay, or any other money due me to satisfy this indebtedness. I further consent to such withholding at a rate sufficient to satisfy this indebtedness no later than my separation, and understand that this could result in the withholding of 100% of any current pay, final pay, or other money due me. I further understand that if and when I do retire, it will be under the provisions of the 1986 Military Retirement Reform Act (1986 MRRA, known as REDUX), and that my future retired pay, if based on length of service, will be reduced under such provisions in the form of a reduced multiplier before age 62 and annual Cost-of-Living Adjustments (COLAs) that are 1 percentage point less than I would otherwise receive both before and after age 62, but with a one-time catch-up COLA adjustment at age 62. I have received the Fact Sheet of Information for Eligible Career Status Bonus Members, explaining the details and effects of making this election.

a. I ELECT TO RECEIVE THE CAREER STATUS BONUS AS FOLLOWS (X the desired option):

- | | |
|--|--|
| <input type="checkbox"/> (1) A SINGLE LUMP SUM PAYMENT OF \$30,000 | <input type="checkbox"/> (4) FOUR ANNUAL PAYMENTS OF \$7,500 |
| <input type="checkbox"/> (2) TWO ANNUAL PAYMENTS OF \$15,000 | <input type="checkbox"/> (5) FIVE ANNUAL PAYMENTS OF \$6,000 |
| <input type="checkbox"/> (3) THREE ANNUAL PAYMENTS OF \$10,000 | |

NOTE: When multiple payments are to be made, the second and later payments are made in January of each succeeding year.

b. SIGNATURE**c. DATE SIGNED (YYYYMMDD)****13. WITNESS****a. PRINTED NAME (Last, First, Middle Initial)****b. RANK/PAY GRADE****c. POSITION/DUTY TITLE****d. ORGANIZATION****e. ORGANIZATIONAL ADDRESS****f. SIGNATURE****g. DATE SIGNED (YYYYMMDD)****SECTION V - ELIGIBLE AND ELECTING NOT TO RECEIVE THE CAREER STATUS BONUS**

Complete this section only if you are eligible to receive the Career Status Bonus but **you desire NOT to elect the bonus**. Then return the form as instructed by your Service.

14. I elect not to receive the Career Status Bonus upon my attainment of 15 years of active duty service. I understand that once the election is effective it may not be revoked. My election is effective once received and accepted at the 15th year of service, or if later, the date received and determined acceptable by my Service, but no later than the date that is six months after being notified of my eligibility. I understand that I will not have any further opportunity to elect to receive this bonus. I understand that I will not receive a bonus payment and that I remain under the High-3 retirement system. I have received the Fact Sheet of Information for Eligible Career Status Bonus Members, explaining the details and effects of making this election not to receive this bonus.

a. SIGNATURE**b. DATE SIGNED (YYYYMMDD)****15. WITNESS****a. PRINTED NAME (Last, First, Middle Initial)****b. RANK/PAY GRADE****c. POSITION/DUTY TITLE****d. ORGANIZATION****e. ORGANIZATIONAL ADDRESS****f. SIGNATURE****g. DATE SIGNED (YYYYMMDD)****SECTION VI - SERVICE RECORDING OF ELECTION**

(To be completed by Service Officials after member makes an election to receive the bonus)

16. CSB ELECTION EFFECTIVE DATE (YYYYMMDD)**17. RECORDING OFFICIAL****a. PRINTED NAME (Last, First, Middle Initial)****b. RANK/PAY GRADE****c. POSITION/DUTY TITLE****d. ORGANIZATION****e. ORGANIZATIONAL ADDRESS****f. SIGNATURE****g. DATE SIGNED (YYYYMMDD)**

INSTRUCTIONS FOR COMPLETING DD FORM 2839, CAREER STATUS BONUS (CSB) ELECTION

GLOSSARY:

CSB Election Effective Date: This is the date the member's election to receive a Career Status Bonus becomes irrevocable. This is the date the election is received and accepted at the 15th year of service, or if later, the date received and determined acceptable by the Service concerned, but no later than the date that is six months after the member is notified of eligibility for the Career Status Bonus.

Date of CSB Notification: This is the date the Service processed the notification to the member. The Service should record this date in Section I, Item 6 of the form as this date may determine the effective date of an election.

Date for Determination of Active Duty Service Completed: This is the date used by the Service to compute the number of years of active duty service of a member. The terminology for this varies by Branch of Service.

Date of Initial Entry to Military Service (or Date of Initial Entry to Uniformed Service): This date is referred to as the **DIEMS** or the **DIEUS**. Other acronyms or terms may be used in other Branches of Service. This is the date someone first became a member of a Uniformed Service and pertains to the earliest date of enlistment, induction, or appointment in a regular or reserve component of a Uniformed Service as a commissioned officer, warrant officer, or enlisted member. Breaks in service shall not affect the date someone first became a member. Cadets and midshipmen of the Academies, cadets of the Reserve Officer Training Corps, and members of the Delayed Entry Program (DEP) are considered to have become members for the purposes of these provisions. All members should be informed of the implications of these provisions on their potential retired pay.

GENERAL

Service Personnel Officials: Complete Sections I, II, and VI as appropriate to member being notified.

Member: Complete only Section III, IV, or V, as appropriate to your situation.

1. Read these instructions carefully before completing the form.
2. This form will record your election to receive a Career Status Bonus. Your election will carry Service obligation requirements and affect your future retired pay.
3. If eligible to elect the Career Status Bonus, your Service must furnish you a copy of the fact sheet: **Information for Members Eligible to Receive a Career Status Bonus** explaining the details and effects of making your election to receive or not to receive the bonus. You should read this fact sheet and consult other sources if desired.

SECTION I: To be completed by Service Officials.

Self-explanatory. Obtain from Service personnel records.

SECTION II: To be completed by Service Officials.

Item 7. This item is to be completed by Service officials and provided to the member on or about the time of completing 14 years and 6 months of active service.

Member: If this item is not completed, obtain a determination from your personnel office.

SECTIONS III, IV and V: To be completed by Member.

Complete only the one section appropriate for your situation. Sign and date the form in the appropriate blocks for the applicable section. Have your signature witnessed as instructed by your Service.

SECTION III: Not Currently Eligible for Career Status Bonus.

Complete Section III only if you have been determined currently **not eligible to elect the bonus**.

SECTION IV: Eligible and Electing to Receive the Career Status Bonus.

Complete Section IV only if you are eligible and **desire to receive the bonus** with associated reductions in future retired pay, and you agree to remain on active duty for a minimum of 20 years.

SECTION V: Eligible and Electing NOT to Receive the Career Status Bonus.

Complete Section V only if you are **eligible but desire NOT to receive the bonus** with associated reductions in retired pay.

SECTION VI: Service Recording of Election.

This section is to be completed by Service officials if the member elects to receive the CSB. If the member was not eligible for the bonus or was eligible but did not elect the bonus, leave this section blank.

Directions To Personnel Clerks Of The Uniformed Services For SGLI Family Coverage Election and Certificate

1. All appropriate items on this form must be completed. All entries except the signature and those requested to be in the servicemember's own handwriting must be typed or printed in ink.
2. The amount of the servicemember's SGLI coverage should be verified to make sure the amount requested for the spouse does not exceed that of the servicemember.
3. An authorized agent of the Uniformed Service must witness the signature of the servicemember. This representative should print his or her name below that of the servicemember and should include the date he or she witnessed the form.
4. This form, properly completed, is authority to a payroll office to change or stop the deductions for Family Coverage premiums if the amount of insurance is changed or canceled.
5. **After the form is completed in its entirety**, you should:
 - Make two photocopies of the completed form (page 2)
 - Distribute as follows (or as directed by your service):

Original Copy (page 2) - Must be promptly filed in the official personnel file of the member
Photocopy 1 (page 2) and **Directions to Servicemember** (page 3) - To servicemember
Photocopy 2 (page 2) - To the Payroll Unit.

Additional copies may be required as directed by your service.

Note: Please do not send any of the forms or copies to the Office of Servicemembers' Group Life Insurance or to the Department of Veterans Affairs.

Please read the instructions before completing this form.

Family Coverage Election

Servicemember's Information

Last name	First name	Middle name	Suffix (Jr., Sr., etc.)	Social Security Number
Branch of Service (Do not abbreviate)				Rank, title or grade

Amount of Insurance

Family Coverage for Dependent Child(ren). By law, if you are insured under SGLI, each of your dependent children (see page 3 for a definition of dependent children for SGLI purposes) is automatically insured for \$10,000.

Family Coverage for Spouse. By law, if you are insured under SGLI, **your spouse is automatically insured for \$100,000 or the amount of your SGLI coverage**, whichever is less. **If you want less than the automatic amount of coverage for your spouse**, please check the appropriate block below and write the amount desired and your initials. Coverage is available in increments of \$10,000. **If you do not want any coverage for your spouse***, check the appropriate block below and write (in your own handwriting), "I do not want coverage for my spouse at this time."

☐ I want coverage in the amount of \$ _____

☐ _____
(Write "I do not want coverage for my spouse at this time.")

***Note:** Reduced or refused family coverage can *only* be restored by completing form SGLV 8285A with proof of good health and compliance with other requirements. It will also affect the amount of insurance your spouse can convert to when Family Coverage expires.

Spouse's Information

(To be completed by member. It is not necessary to complete this section if you're declining coverage.)

Last name	First name	Middle name	Suffix (Jr., Sr., etc.)	Social Security Number
Date of Birth (dd-mmm-yyyy e.g. 24-AUG-1965)				

Premiums for Spousal Coverage

Spouse's age:	Monthly rate per \$10,000	Monthly cost for \$100,000 coverage
Under 35	\$.90	\$9.00
35-44	\$1.30	\$13.00
45-49	\$2.00	\$20.00
50-54	\$3.20	\$32.00
55 & older	\$5.50	\$55.00

I HAVE READ AND UNDERSTAND the instructions on pages 2 and 3 of this form and certify that the information I have provided is correct.

SIGNATURE OF SERVICEMEMBER ➤ _____

Date: _____
(dd-mmm-yyyy
e.g. 01-NOV-2001)

Do not write in space below. For official use only.

Witnessed and received by: (please print)	Rank, title or grade	Organization	Date Received (dd-mmm-yyyy e.g. 01-NOV-2001)
---	----------------------	--------------	---

Directions To Servicemember

Instructions For Completing This Form

1. Type or print in ink all items except where otherwise noted.
2. An authorized agent of the Uniformed Services should witness your signature.

What You Should Know

Family Coverage is granted under the Servicemembers' Group Life Insurance provisions of title 38, United States Code, and is subject to this law and the regulations pertaining to this law.

Periods of Coverage

Coverage for spouses begins on November 1, 2001 for servicemembers insured under SGLI who are married as of that date. Otherwise, coverage for spouses begins on the date of marriage to the insured servicemember.

Coverage for spouses ends 120 days after any the following events:

- 1). The date a servicemember elects in writing to terminate the spousal coverage.
- 2). The date a servicemember elects in writing to terminate his or her own coverage.
- 3). The date of a servicemembers' death.
- 4). The date a servicemember separates or is released from the uniformed service.
- 5). The date of divorce from a servicemember.

An insured spouse may elect to convert his or her coverage to a commercial policy within 120 days following one of the events listed above. The servicemember or spouse must contact the Office of Servicemembers' Group Life Insurance (OSGLI) as soon as possible after the event to get a list of participating companies and more information on converting. A list of participating companies can also be found at www.insurance.va.gov.

Coverage for dependent children of servicemembers insured under SGLI begins on November 1, 2001. Otherwise, coverage for natural children begins on the date of birth of the child. Coverage for those who are not natural children of the insured servicemember begins on the date when the child becomes a qualified dependent of the member. Dependent children include, but is not limited to, natural born children, legally-adopted children, and stepchildren who are members of the servicemember's household, who are under the age of 18, or who became permanently incapable of self-support prior to age 18, or who are under age 23 and are full-time students. For a more complete definition of dependent children, please refer to title 38 USC, the first sentence of section 101(4)(A).

Coverage for children ends 120 days after any of the following events:

- 1). The date a servicemember elects in writing to terminate his or her own coverage.
- 2). The date a servicemember separates or is released from the uniformed service.
- 3). The date of a servicemember's death.
- 4). The date the children no longer qualify as an insurable dependent of the servicemember.

Provisions For Payment Of Insurance

The servicemember will receive the proceeds upon the death of his or her spouse or child. If two insured servicemembers are married, the proceeds paid from the death of a child will be paid to the member who was eligible for SGLI coverage the longest. If an insured servicemember is separated or divorced from another insured servicemember, insurance proceeds from the death of a child will be paid to the member who has custody of the child.

How To File A Claim

Upon the death of your spouse or child, you should notify the Casualty Office within your branch of service. The Casualty Office will submit a *Report of Death of Family Member (SGLV 8700)* and a copy of the death certificate to the Office of Servicemembers' Group Life Insurance.

LEAVE REQUEST / AUTHORIZATION
NAVCOMPT FORM 3065 (3PT) (REV - 2-83)

INSTRUCTIONS FOR COMPLETING THIS FORM ARE
 ON THE **REVERSE OF PART 3.**

SEE REVERSE FOR
 PRIVACY ACT
 STATEMENT

1. DATE OF REQUEST		2. FOR ADMIN, USE ONLY APPROVAL OF THIS LEAVE IS NOT VALID WITHOUT CONTROL NO.		LEAVE CONTROL NO.	
3. SSN		4. NAME (Last, First, MI)			5. PAY GRADE
6. SHIP / STATION		7. DEPT / DIV	8. DUTY SECTION	9. DUTY PHONE	
10. TYPE LEAVE <input type="checkbox"/> REGULAR <input type="checkbox"/> SICK <input type="checkbox"/> EMERGENCY <input type="checkbox"/> SEPARATION <input type="checkbox"/> RETIREMENT <input type="checkbox"/> OTHER: _____		FOR USE OUTUS ONLY		12. MODE OF TRAVEL <input type="checkbox"/> AIR <input type="checkbox"/> BUS <input type="checkbox"/> CAR <input type="checkbox"/> TRAIN	
		11a. Leaving Area of PERMDUTYSTA <input type="checkbox"/> YES <input type="checkbox"/> NO			
		11b. Taking Leave INCONUS <input type="checkbox"/> YES <input type="checkbox"/> NO			
13. DAYS REQUESTED	14. FROM (Hr., Date) (YYMMDD)	15. TO (Hour, Date) (YYMMDD)		16. NORMAL WORKING HOURS DAY OF DEPARTURE: FROM: TO: DAY OF RETURN: FROM: TO:	
17. LEAVE BALANCE DAYS AS OF	18. LEAVE USED THIS FY	19. LEAVE PHONE			
20. LEAVE ADDRESS					
				21. RATION STATUS (Enlisted) <input type="checkbox"/> COMMUTED RATIONS (COMRATS) Meal Pass No. _____ <input type="checkbox"/> Entitled to EDF meals except during periods of leave.	

I CERTIFY THAT I HAVE SUFFICIENT FUNDS TO COVER THE COST OF ROUND TRIP TRAVEL.
 I UNDERSTAND THAT SHOULD ANY PORTION OF THIS LEAVE, IF APPROVED, RESULT IN MY
 TAKING MORE LEAVE THAN I CAN EARN ON MY CURRENT UNEXTENDED ENLISTMENT OR
 CURRENT ACTIVE DUTY OBLIGATION, MY PAY WILL BE CHECKED FOR SUCH EXCESS LEAVE.

22. SIGNATURE OF APPLICANT

RECOMMENDED <input type="checkbox"/> YES <input type="checkbox"/> NO			DATE
<input type="checkbox"/> YES <input type="checkbox"/> NO			DATE
<input type="checkbox"/> YES <input type="checkbox"/> NO			DATE
<input type="checkbox"/> YES <input type="checkbox"/> NO			DATE
23. APPROVED <input type="checkbox"/>	DISAPPROVED <input type="checkbox"/>	REVIEWING OFFICER'S NAME AND SIGNATURE	DATE
24. COMMENTS / REMARKS			

25. SHIP OR STATION (Including telegraphic address)		26. REPORT ON EXPIRATION OF LEAVE TO (If other than block 25)			
DEPARTED ON LEAVE		RETURNED FROM LEAVE		GRANTED EXTENSION OF LEAVE ENDING	
27a. HOUR	27b. DATE (YYMMDD)	28a. HOUR	28b. DATE (YYMMDD)	29a. HOUR	29b. DATE (YYMMDD)
27c. OOD'S SIGNATURE		28c. OOD'S SIGNATURE		29c. AUTHORIZING OFFICER'S SIGNATURE	
IN CONSIDERATION OF THE MEMBER'S COMPLETION OF A FULL WORKDAY (AS DEFINED IN MILPERSMAN, NAVPERS 15560) ON THE DAYS OF DEPARTURE AND RETURN, THE INCLUSIVE DAYS SHOWN ARE CORRECT AND PROPER FOR CHARGING AS LEAVE.		30. INCLUSIVE LEAVE PERIOD TO BE CHARGED	FIRST: (YY) (MM) (DD)		31. NO. OF DAYS
			LAST: (YY) (MM) (DD)		
I CERTIFY THAT THE ABOVE IS CORRECT AND PROPER TO THE BEST OF MY KNOWLEDGE.		32. CERTIFYING OFFICER'S TYPED NAME / RANK / TITLE		33. CERTIFYING OFFICER'S SIGNATURE	

FORWARD THIS COPY TO PERSONNEL OFFICE VIA COMMAND ONLY ON COMPLETION OF LEAVE.

SERVICE RECORD PAGE 4 ENTRIES REQUEST FORMPREPARE ORIGINAL AND ONE COPY. FILE ORIGINAL IN T/R
WHEN ENDORSED; FILE 2ND COPY IN UNIT FILE

Date: _____

UIC: _____

From: _____

To: Officer in Charge, PERSUPPDET _____

Subj: SERVICE RECORD PAGE 4 ENTRIES ICO _____
(Rank/Rate, First Name, MI, Last Name, SSN)

Provide e-mail address for quick confirmation that entry has been made.

1. Military schools and other training completed:

Title of course of instruction: _____

NAVEDTRA #: _____ COURSE #: _____ FROM: _____ TO: _____

NEC EARNED: _____ GRADE: _____ CONDUCTED AT: _____

2. Advancement Requirements:

a. Completed Professional Course for _____, NAVEDTRA # _____
with a grade of _____ on _____b. Completed Military course for _____, NAVEDTRA # _____
with a grade of _____ on _____

c. Completed PARS for _____ on _____

3. Correspondence Course/PQS Completed:

CORRESPONDENCE COURSE/ PQS TITLE	WATCHSTATION # OR NAVEDTRA #	DATE COMPLETED	GRADE

4. College Course(s) Completed:

COLLEGE COURSE(S) TITLE	SCHOOL ATTENDED	DATE COMPLETED	GRADE

5. Awards Received: (i.e. Personal Military Decorations, Good Conduct, Unit/Campaign/Service, Good Conduct, Military-Related Letter of Commendation) (Attach copy of citation certificate for all except Unit/Campaign and Good Conduct Medal.)

AWARDS RECEIVED	DATE OF AWARD	AWARDING AUTHORITY/ REFERENCE CORRESPONDENCE	INITIAL

PSD ROUTING
INDICATOR

DATE RECEIVED: _____

DATE ROUTED TO OPIM: _____

ESO/Training Petty Officer/E-mail _____

FIRST ENDORSEMENT

Date: _____

From: Officer in Charge, PERSUPPDET _____

To: _____

Subj: COMPLETION OF SERVICE RECORD PAGE 4 ENTRIES/PAGE 13 (OFFICERS)

1. Service record entry(ies) has/have been completed this date.

By direction _____

MEMBER'S NAME		SSN	DATE
PRESENT SHIP/STATION	UIC	OVERSEAS LOCATION	UIC
		ISOLATED <input type="checkbox"/> YES <input type="checkbox"/> NO	

YES NO

- (1)

MEMBER'S NAME	SSN	DATE
<p>YES NO</p> <p>9. <input type="checkbox"/> <input type="checkbox"/> Are any of the member's family members covered in a custody agreement? If "NO," go to question 10.</p> <p> <input type="checkbox"/> <input type="checkbox"/> a. Does agreement prevent removal of family members from CONUS without prior court approval or agreement between the interested parties? If "NO," go to question 10.</p> <p> <input type="checkbox"/> <input type="checkbox"/> b. Has member obtained prior court approval of requisite agreement from other interested party for removal of family members from CONUS, if required by state law? (<u>Please note:</u> Navy policy does not require a separate agreement if not required by state law.)</p> <p>10. <input type="checkbox"/> <input type="checkbox"/> Is the member within standards to transfer IAW PRT standards?</p> <p>11. <input type="checkbox"/> <input type="checkbox"/> (Single parents/military couples with family members.) Have family member care requirements been met in accordance with OPNAVINST 1740.4 series?</p> <p>NOTE: While the unique situation of single parents with family members is not in itself disqualifying, this fact should be pointed out upon submission of message certification of screening to NAVPERSCOM (PERS-40)/(PERS-451)/(EPMAC.)</p> <p>12. <input type="checkbox"/> <input type="checkbox"/> FOR PERSONNEL E-3 AND BELOW: Has the member been counseled that personnel in these paygrades, having family members, will not be assigned accompanied overseas duty ? Members can be assigned unaccompanied based on readiness needs. (NOTE: Single E-3 and below who acquire (a) family member(s) en route and bring them without dependent entry approval/command sponsorship along, will most probably return them at personal expense and serve the complete area tour unaccompanied.)</p> <div style="text-align: right; margin-right: 100px;"> <p>_____ Member's signature</p> <p>_____ Date</p> </div> <p>13. <input type="checkbox"/> <input type="checkbox"/> Has member received a unsatisfactory or marginal performance mark in the last two (2) years progressing or recommended is suitable?</p> <p>14. <input type="checkbox"/> <input type="checkbox"/> Has member and adult dependents received "Level I" Antiterrorism – Force Protection (Level III for O-5/O-6 Commanding Officer Awareness Training), prior to transfer, and recorded on Page 13? (Contact your local Family Service Center if training is not available at your command)</p> <p>REMARKS: _____</p> <p>_____</p> <p>I, _____, am aware that the failure to divulge disqualifying information or amplifying information (medical/dental/personal) pertaining to the questions on this checklist may ultimately result in disciplinary action punishable under the UCMJ.</p> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 30%;"> <p>_____ MEMBER (Signature)</p> </div> <div style="width: 20%;"> <p>_____ DATE</p> </div> <div style="width: 30%;"> <p>_____ MEMBER (Name, Rank/Rate)</p> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 30%;"> <p>_____ INTERVIEWER (Signature)</p> </div> <div style="width: 20%;"> <p>_____ DATE</p> </div> <div style="width: 30%;"> <p>_____ INTERVIEWER (Name, Rank/Rate) (CMD Title)</p> </div> </div>		

MEMBER'S NAME

SSN

DATE

PART II: RECOMMENDATION OF COMMANDING OFFICER (OR OIC) OF MEDICAL TREATMENT FACILITY.

Based on the information available as a result of screening and on the capabilities of the Medical/Dental Treatment Facility in the area of assignment to which ordered, the following recommendation is forwarded:

- YES NO (Military member)
1. ☐ ☐ Complete BUMED 1300/1 part I and II, if shaded block has a negative answer, provide endorsement from gaining MTF/DTF?
- (Family members Medical/Dental)
2. ☐ ☐ Are family members recommended for overseas assignment? If tour is a 24 month or less unaccompanied tour (except for Diego Garcia and Souda Bay Crete), screening not required. If shaded block has a negative answer, provide endorsement from gaining MTF/DTF.
3. ☐ ☐ EFM category, if applicable. (EFM category _____) Attach gaining command's endorsement.

Signature of CO/OIC or Designee
of Medical Treatment Facility

Date

Print name of CO/OIC or Designee
of Medical Treatment Facility

PART III: COMMANDING OFFICER'S ENDORSEMENT

On the basis of all available information, I endorse _____ /I do not endorse _____ (check one) the member's orders for the overseas assignment.

Commanding Officer (Signature)

Date

Commanding Officer (Name, Rank)

PRIVACY ACT STATEMENT: The authority to request this information is contained in 5 USC 301 Departmental Regulations. The information will be used to assist officials and employees of the Department of the Navy in determining your future duty assignment. Completion of the form is mandatory except for duty and home phone numbers; failure to provide required information may result in delay in response to or disapproval of your request.

AUTHORIZATION TO APPLY FOR A "NO-FEE" PASSPORT AND/OR REQUEST FOR VISA		1. DATE PASSPORT OR VISA REQUIRED BY APPLICANT		2. MAJOR SERVICE COMPONENT	
3. APPLICANT'S LAST NAME - FIRST NAME - MIDDLE NAME		4. APPLICANT'S DATE OF BIRTH		5. APPLICANT'S PLACE OF BIRTH	
6. SPONSOR'S LAST NAME - FIRST NAME - MIDDLE NAME		7. SPONSOR'S MILITARY RANK/CIVILIAN GRADE		8. SPONSOR'S SSN	
<input type="checkbox"/> (If same as Item 3, X block)					
9.a. APPLICANT'S CURRENT HOME ADDRESS (Include ZIP Code)		b. HOME TELEPHONE NUMBER (Include area code)			
		c. OFFICE TELEPHONE NUMBER (Include area code/DSN)			
10.a. INTERIM ADDRESS WHERE APPLICANT MAY BE CONTACTED AFTER DEPARTING LOCATION INDICATED IN ITEM 9 (Include ZIP Code)		b. NAME OF PERSON WITH WHOM RESIDING			
		c. TELEPHONE (Incl. area code)		d. AGENT ID CODE (If applicable)	
11. DESTINATION (Country or Countries)		12. SPECIAL ASSIGNMENT REQUIRING PASSPORT* (See Note)		13. PASSPORT WILL BE FORWARDED TO: (Include complete mailing address, building number, room number, ZIP Code, and telephone number/DSN)	
14. ESTIMATED DATE OF DEPARTURE (From country in which applicant is currently residing)		15. PROPOSED LENGTH OF STAY			
17. ADDITIONAL INFORMATION (Attach continuation sheets if necessary)		16. AUTHORIZING OFFICIAL			
		a. NAME (Last, First, Middle Initial)			
		b. GRADE		c. TITLE	
		d. COMPLETE MAILING ADDRESS (Include ZIP Code)			
		e. TELEPHONE NUMBER (Include area code/DSN)			
		f. SIGNATURE OF AUTHORIZING OFFICIAL		g. DATE	
FOR USE BY ISSUING OR RECEIVING AGENT (Suspense Control)					
18. DATE APPLIED FOR PASSPORT		19. PLACE APPLIED FOR PASSPORT		20. NAME OF COURT OR PASSPORT AGENT	
21. DATE PASSPORT RECEIVED FROM DEPARTMENT OF STATE		22. PASSPORT NUMBER		23. DATE OF PASSPORT ISSUE	
24. PASSPORT EXPIRATION DATE					
25. DOCUMENT(S) INCLUDED WITH PASSPORT		26. COUNTRY AND DATE VISA REQUESTED		27. DATE PASSPORT RECEIVED WITH VISA	
				28. DATE PASSPORT MAILED	
PRIVACY ACT STATEMENT					
AUTHORITY: Sections 3012, 8012, 5031, Title 10 USC; 22 CFR 51.63; EO 9397.					
PRINCIPAL PURPOSE: To provide authority for issue of "No-Fee" passport and/or request for a visa which is an endorsement stamped or written on a passport, showing that it has been examined by the proper officials of a country and granting entry into that country. The Social Security Number is required to verify and/or identify the applicant.					
ROUTINE USES: Information is used in conjunction with application for passport/visa and foreign travel. Information may be released to other DoD agencies, various activities within the Department of State, foreign embassies and consulates.					
DISCLOSURE: Voluntary; however, if applicant does not provide information, a "No-Fee" passport cannot be authorized.					
*NOTE: If assignment is to Attache; MAAG; JUSMMAT; Security Assistance Liaison Office (SALO); OSP or other Special Advisory Group, e.g., CENTO; or any particular assignment that will govern type and need for a passport, enter such information. If not, enter "Not Applicable."					

(CH-2, 19SEP03)

Reporting Member's RECEIPT PACKAGE

*The following items must be properly completed and submitted to your Command Pass Liaison Representative (PLR), in order to obtain an appointment for Receipts processing. **Incomplete packages will prevent member from being assigned an appointment.***

1. Member's Personal Information Sheet
2. Pen and ink changes to existing Page 2 and SGLI.
3. Member's Receipt Check-Off List signed by Command's PLR.
4. Original and 3 copies of the orders (with reporting endorsement from command).
5. Original and a copy of **COMPLETED** Travel Claim(s) (DD Form 1351-2) with supporting documents (i.e. lodging receipts, plan ticket receipts, etc). Complete Missing Receipt Form if necessary. See Travel Claim Check Off Sheet for help.
6. Temporary Lodging Expense (TLE) Claim form for CONUS expenses and if entitled. Provide copy of lodging receipts to match claim.
7. Temporary Lodging Allowance (TLA) Information Sheet (If member is authorized by Housing Office)
8. Command approval letter for the following, if applicable:
 - a. COMRATS/BAS (approved appropriately)
 - b. Authorization to live off-base,
 - c. Special Pays (SDAP, Dive Qualifications, Foreign Language Evaluations, Responsibility Pay, etc.)

Additional information for Mobilization & ADSW members:

9. Completed Direct Deposit Sign-Up Form
10. Completed State of Legal Residence Certificate
11. Completed W4 (Employee's Withholding Allowance Certificate)

IMPORTANT: SERVICE RECORD WILL BE KEPT IN THE PSD RECEIPTS SECTION FIVE (5) WORKING DAYS FROM PROCESSING DATE. RECORD WILL NOT BE ACCESSIBLE DURING THIS PROCESS PERIOD.

Special Note:

If applying for Family Type Government Quarters or TLA, prepare the following package for Housing:

- (a) Copy of ENDORSED Orders
- (b) Copy of Enlisted member's Page 5 or Last PDS detaching endorsement.
- (c) Copy of member's pen & ink changes of Page 2.

MEMBER'S PERSONAL INFORMATION SHEET

NAME	NEW
SSN	COMMAND
RATE	UIC
RANK	REPORT
Member's	DATE
Resident	Last
Address	Transfer
PHONE #	Date
EMAIL	Work
	Phone #
	Special
	Pays
	ON TLA
	YES
	NO

DEPENDENT PCS INFORMATION

Dependents Name (Who PCS)	Relationship	Age	Date Arrived
Depns			
Current			
Address			

Pass Liaison Representative's RECEIPTS CHECK-OFF LIST

MEMBER'S RATE/RANK AND NAME/COMMAND:		
PLRS' INITIAL		
	COMPLETED Member's Personal Information Sheet	
	Pen & ink changes to existing Emergency Data (Page 2) <i>Ensure PNOK/SNOK is designated with current address and phone numbers.</i>	
	Pen & Ink changes to existing SGLI. <i>Ensure beneficiaries reflect current address and coincides with Page 2 information</i>	
	Original and three (3) copies of Command ENDORSED Orders (full set of orders, not just the first page). <i>Ensure copies reflect legible reporting endorsement.</i>	
	Original and one (1) copy of COMPLETED Travel Claim with supporting travel itinerary, receipts (travel/hotel), BEQ/BOQ statement of non assignment, Pet Quarantine, etc. Note: Complete missing Receipt Form if necessary.	
	COMPLETED Temporary Lodging Expense (TLE) Claim, if applicable to member supported with hotel receipts. (Conus to Out-Conus)	
	COMPLETED Temporary Lodging Allowance Information Sheet, if member is eligible for TLA. Must be authorized by Housing Office.	
	Approved Special Request Chit or letter for COMRATS/BAS (by COMAVREG) if applicable/available	
	BEQ/BOQ Check out Sheet and COMNAVREG approval to live off base if applicable.	
	Command memo to start Special Pays (SDAP, Dive Pay, Foreign Language, etc.)	
	For ADSW/Mobilization Members Only:	
	COMPLETED Direct Deposit Sign-Up Form with cancelled check for sample.	
	COMPLETED State of Legal Residence Certificate	
	COMPLETED Employee's Withholding Allowance Certificate W4	
	Acknowledgement by Command PLR: "I certify the above to be complete for Receipt Processing. I understand that an incomplete package will prevent member from being assigned an appointment." <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; border-top: 1px solid black; text-align: center;">Command PLR's Signature</div> <div style="width: 45%; border-top: 1px solid black; text-align: center;">Date</div> </div>	
	Phone Number:	Email:

Travel Claim Check Off Sheet

Rev: 9/03

The following travel claim package must be verified and assembled in below orders by PLRs prior to forwarding to Receipts Division or Travel Division for processing.

- DD Form 1351-2 Travel Voucher or Subvoucher
- Endorsed Travel Orders
- Amendments
- Lodging Receipts and Temporary Lodging Expense Certificate (if applicable)
- Rental Car Receipts
- Flight Itinerary
- Any receipts which can be provided. Mandatory submission of receipts is required for expenses over \$75.00 (Submit Certificate of Unaavilable/Lost Receipt Form, if necessary)

Points to Remember:

All information asked for on the form MUST be filled out in it's entirety. Additionally, email address for both PLR and Traveler must be provided. If the traveler has classified email address and we are unable to contact the traveler, the traveler must indicate a secondary/backup email address. A suggestion is to provide another POC within the Admin department/PLR/Travel Coordinator's email address. Bottom line, Travel Section needs two email addresses provided on the transmittal sheet.

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. Section 5701, 37 U.S.C. Sections 404 - 427, 5 U.S.C. Section 301, DoDFMR 7000.14-R, Vol. 9, and E.O. 9397.

PRINCIPAL PURPOSE(S): This record is used for reviewing, approving, accounting, and disbursing money for claims submitted by Department of Defense (DoD) travelers for official Government travel. The Social Security number (SSN) is used to maintain a numerical identification filing system for filing and retrieving individual claims.

ROUTINE USE(S): Disclosures are permitted under 5 U.S.C. 552a(b), Privacy Act of 1974, as amended. In addition, information may be disclosed to the Internal Revenue Service for travel allowances, which are subject to Federal income taxes, and for any DoD "Blanket Routine Use" as published in the Federal Register.

DISCLOSURE: Voluntary; however, failure to furnish the information requested may result in total or partial denial of the amount claimed.

PENALTY STATEMENT

There are severe criminal and civil penalties for knowingly submitting a false, fictitious, or fraudulent claim (U.S. Code, Title 18, Sections 287 and 1001 and Title 31, Section 3729).

INSTRUCTIONS

ITEM 1 - PAYMENT

Member must be on electronic funds (EFT) to participate in split disbursement. Split disbursement is a payment method by which you may elect to pay your official travel card bill and forward the remaining settlement dollars to your predesignated account. For example, \$250.00 in the "Amount to Government Travel Charge Card" block means that \$250.00 of your travel settlement will be electronically sent to the charge card company. Any dollars remaining on this settlement will automatically be sent to your predesignated account. Should you elect to send more dollars than you are entitled, "all" of the settlement will be forwarded to the charge card company. Notification: you will receive your regular monthly billing statement from the Government Travel Charge Card contractor; it will state: paid by Government, \$250.00, 0 due. If you forwarded less dollars than you owe, the statement will read as: paid by Government, \$250.00, \$15.00 now due. Payment by check is made to travelers only when EFT payment is not directed.

REQUIRED ATTACHMENTS

1. Original and/or copies of all travel orders and amendments, as applicable.
2. Two copies of dependent travel authorization if issued.
3. Copies of secretarial approval of travel if claim concerns parents who either did not reside in your household before their travel and/or will not reside in your household after travel.
4. Copy of GTR, MTA or ticket used.
5. Hotel/motel receipts and any item of expense claimed in an amount of \$75.00 or more.
6. Other attachments will be as directed.

ITEM 15 - ITINERARY - SYMBOLS

15c. MEANS/MODE OF TRAVEL *(Use two letters)*

GTR/TKT	- T	Automobile	- A
Government Transportation	- G	Motorcycle	- M
Commercial Transportation		Bus	- B
<i>(Own expense)</i>	- C	Plane	- P
Privately Owned		Rail	- R
Conveyance <i>(POC)</i>	- P	Vessel	- V

15d. REASON FOR STOP

Authorized Delay	- AD	Leave En Route	- LV
Authorized Return	- AR	Mission Complete	- MC
Awaiting Transportation	- AT	Temporary Duty	- TD
Hospital Admittance	- HA	Voluntary Return	- VR
Hospital Discharge	- HD		

ITEM 15e. LODGING COST

Enter the total cost for lodging.

ITEM 19 - DEDUCTIBLE MEALS

Meals consumed by a member/employee when furnished with or without charge incident to an official assignment by sources other than a government mess (*see JFTR, par. U4125-A3g and JTR, par. C4554-B for definition of deductible meals*). Meals furnished on commercial aircraft or by private individuals are not considered deductible meals.

29. REMARKS

INDICATE DATES ON WHICH LEAVE WAS TAKEN:

TEMPORARY LODGING EXPENSE CERTIFICATE

NAME: _____ SSN: _____

OLD PDS: _____ NEW PDS: _____

OLD ADDRESS: _____ NEW ADDRESS: _____

DEPENDENT NAME	RELATIONSHIP	BIRTH/MARRIAGE DATE

MEMBER

DATE DETACH OLD PDS: _____

DATE REPORT NEW PDS: _____

DEPENDENTS

DATE DETACH OLD PDS: _____

DATE REPORT NEW PDS: _____

DATE QUARTERS/RESIDENCE VACATED: _____

NAME AND ADDRESS OF TEMPORARY LODGING FACILITY:

DAILY LODGING COST: _____ HOW MANY RESIDED IN TEMPORARY LODGING? _____

MONTHLY RATE OF BAH: _____ DAILY RATE OF BAS: _____

FROM: _____ TO: _____
CHECK IN DATE CHECK OUT DATE

DID THE TEMPORARY LODGING HAVE FACILITIES FOR PREPARING FOOD? (Y/N) _____

WAS GOV MESS USED FOR ALL THREE MEALS DAILY? (Y/N) (MEMBER ONLY) _____

DID THE MEMBER AND DEPENDENTS RESIDE WITH FAMILY OR FRIENDS? (Y/N) _____

CERTIFICATION

I certify that in connection with my PCS transfer I was required to obtain temporary lodging for:

☐ Myself

☐ Dependent(s) Only

☐ Myself & My Dep(s)

Signature: _____ Date: _____

*** Use a separate form for EACH lodging location.

*** Navy Lodge MUST be used prior to using commercial lodging.

*** Final lodging receipt is REQUIRED.

CERTIFICATION FOR UNAVAILABLE/LOST RECEIPT

I HEREBY CERTIFY THAT I INCURRED THE FOLLOWING EXPENSE(S) FOR WHICH THE RECEIPT IS UNAVAILABLE AND/OR LOST FOR PRESENTATION WITH THIS TRAVEL CLAIM.

LODGING EXPENSES:

PROCURED AT: _____
(Hotel Name, City, State/Country)
FOR PERIOD _____ THRU _____ AT A COST OF
\$ _____ PER DAY, FOR A TOTAL COST OF \$ _____

PROCURED AT: _____
(Hotel Name, City, State/Country)
FOR PERIOD _____ THRU _____ AT A COST OF
\$ _____ PER DAY, FOR A TOTAL COST OF \$ _____

AIRLINE TICKET(S):

FROM _____ TO _____ DATE _____ COST _____

RENTAL CAR:

FROM _____ TO _____ DATE _____ COST _____

PROVIDE STATEMENT EXPLAINING WHY RECEIPT ISN'T FURNISHED

I AM SUBMITTING THIS STATEMENT IN LIEU OF UNAVAILABLE AND/OR LOST RECEIPT(S). I MAKE THE FOREGOING CERTIFICATION WITH THE FULL KNOWLEDGE OF THE PENALITIES FOR WILLFULL MAKING A FALSE STATEMENT (18 USC 1001). I UNDERSTAND THAT IF ANY PORTION OF THE CLAIM IS DETERMINED TO BE FRAUDULANT, PAYMENT FOR THE ENTIRE CLAIM MAY BE DENIED.

Signature/Date

ARRIVAL TEMPORARY LODGING ALLOWANCE (TLA) INFORMATION SHEET
--

NAME (Last, First, MI):	RANK/RATE:	SSN:
COMMAND:	UIC:	WORK PHONE:
REPORT DATE:	TLA HOTEL:	

INITIALS	
----------	--

	The purpose of TLA is to PARTIALLY reimburse a member for more than normal expenses incurred while occupying temporary lodging accommodations.
	FAMILY MEMBERS MUST BE COMMAND-SPONSORED prior to the effective date of orders.
	TLA is payable in 10 or less day increments, with a paid receipt and TLA authorization, not to exceed 60 calendar days (including periods of TAD off the island) from the date of reporting. Waivers may be requested via letter to COMNAVBASE Pearl Harbor.
	TLA is not payable to the member while on leave (prior to report date) or TAD off the island. If the member is TAD off the island, TLA may be paid only for family members who remain on island.
	TLA is payable when staying with friends/relatives (meal allowance only) or in temporary lodging on the island of Oahu only.
	Immediately after reporting to command, personnel arriving with their family members are <u>required</u> to register with the Navy Aloha Center within 72 hours for a housing assignment appointment and TLA authorization due to non-availability of government quarters. The member or a family member (with power of attorney) is required to have a copy of permanent change of station (PCS) orders (with command reporting endorsement), the detaching endorsement and the Page 2 (Record of Emergency Data).
	Single and geographical bachelors must check-in with the BOQ/BEQ to obtain lodging. If lodging is not available, the member will be issued a non-availability of government quarters stamp on their original orders and a TLA authorization letter from the BOQ/BEQ. If a non-availability is issued, the member must then register with the Navy Housing Referral Office to show active search for permanent quarters. Single and geographical bachelors attached to an Afloat command are NOT eligible to receive TLA.
	The Navy Aloha Center and Housing Referral Office is located at 988 Spence Street (Bldg 2562) adjacent to Moanalua Shopping Center and can be contacted at 474-1800.
	All payments are made via EFT to the bank account where regular pay is deposited. EFT payments normally post to the bank account within 3 working days after claim submission.
	Member may submit TLA claim NO EARLIER THAN the 7 th day of the 10 th day increment. Member must have been processed on board new duty station and provide valid paid or advance hotel receipts and TLA authorization from Housing.
	Final TLA will NOT be paid unless Page 2 and SGLI is updated and signed by member reflecting new permanent address. In addition to the final TLA documents, documentation of government quarter's assignment or rental/mortgage agreement is required. The TLA Clerk will update/start applicable station allowances (i.e. BAH and/or COLA).

"I have been briefed and understand the provisions regarding entitlement to Arrival TLA and my responsibilities as contained in COMNAVBASEPEARLINST 7220.2d and will promptly notify the command of any change in statutes affecting entitlement thereto."

(Member's signature)

DIRECT **DEPOSIT** SIGN-UP FORM

DIRECTIONS

- To sign up for direct deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 (TO BE COMPLETED BY PAYEE)

A NAME OF PAYEE (<i>last, first, middle initial</i>)		D TYPE OF DEPOSITOR ACCOUNT <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS	
ADDRESS (<i>street, route, P.O. Box, APO/FPO</i>)		E DEPOSITOR ACCOUNT NUMBER <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
CITY	STATE	ZIP CODE	
TELEPHONE NUMBER AREA CODE		F TYPE OF PAYMENT (<i>Check only one</i>) <input type="checkbox"/> Social Security <input type="checkbox"/> Fed Salary/Mil. Civilian Pay <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> Mil. Active _____ <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Mil. Retire. _____ <input type="checkbox"/> Civil Service Retirement (OPM) <input type="checkbox"/> Mil. Survivor _____ <input type="checkbox"/> VA Compensation or Pension <input type="checkbox"/> Other _____ <div style="text-align: right;"><i>(specify)</i></div>	
B NAME OF PERSON(S) ENTITLED TO PAYMENT		G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY (<i>if applicable</i>)	
C CLAIM OR PAYROLL ID NUMBER Prefix _____ Suffix _____		TYPE	AMOUNT
PAYEE/JOINT PAYEE CERTIFICATION I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.		JOINT ACCOUNT HOLDERS' CERTIFICATION (<i>optional</i>) I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.	
SIGNATURE	DATE	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

SECTION 2 (TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
------------------------	---------------------------

SECTION 3 (TO BE COMPLETED BY FINANCIAL INSTITUTION)

NAME AND ADDRESS OF FINANCIAL INSTITUTION		ROUTING NUMBER		CHECK DIGIT
		<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>		<div><div></div></div>
		DEPOSITOR ACCOUNT TITLE		

FINANCIAL INSTITUTION CERTIFICATION			
I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.			
PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or record-keeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A) Be sure that the payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C) Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F) Type of payment is printed to the left of the amount.

United States Treasury ¹⁵⁻⁵¹/₁₀₀₀

AUSTIN, TEXAS

Check No. 0000 - 4157815

Month Day Year
08 31 84

Pay to the order of
JOHN DOE
123 BRISTOL STREET
HAWKINS BRANCH, TX 76543

29-693-775 00 C

28 28
VA COMP

DOLLARS CTS
\$ ****100**00

NOT NEGOTIABLE

@000000516 041571926

SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until canceled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete the new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than \$10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

STATE OF LEGAL RESIDENCE CERTIFICATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Tax Reform Act of 1976, Public Law 94-455.

PURPOSE: Information is required for determining the correct State of legal residence for purposes of withholding State income taxes from military pay.

ROUTINE USES: Information herein will be furnished State authorities and to Members of Congress.

MANDATORY OR VOLUNTARY DISCLOSURE: Disclosure is voluntary. If not provided, State income taxes will be withheld based on the tax laws of the State previously certified as your legal residence, or in the absence of a prior certification, the tax laws of the applicable State based on your home of record.

NAME (Last, first, middle initial)

SOCIAL SECURITY NUMBER (SSN)

LEGAL RESIDENCE/DOMICILE (City or county and State)

INSTRUCTIONS FOR CERTIFICATION OF STATE OF LEGAL RESIDENCE

The purpose of this certificate is to obtain information with respect to your legal residence/domicile for the purpose of determining the State for which income taxes are to be withheld from your "wages" as defined by Section 3401(a) of the Internal Revenue Code of 1954. PLEASE READ INSTRUCTIONS CAREFULLY BEFORE SIGNING.

The terms "legal residence" and "domicile" are essentially interchangeable. In brief, they are used to denote that place where you have your permanent home and to which, whenever you are absent, you have the intention of returning. The Soldiers' and Sailors' Civil Relief Act protects your military pay from the income taxes of the State in which you reside by reason of military orders unless that is also your legal residence/domicile. The Act further provides that no change in your State of legal residence/domicile will occur solely as a result of your being ordered to a new duty station.

You should not confuse the State which is your "home of record" with your State of legal residence/domicile. Your "home of record" is used for fixing travel and transportation allowances. A "home of record" must be changed if it was erroneously or fraudulently recorded initially.

Enlisted members may change their "home of record" at the time they sign a new enlistment contract. Officers may not change their "home of record" except to correct an error, or after a break in service. The State which is your "home of record" may be your State of legal residence/domicile only if it meets certain criteria.

The formula for changing your State of legal residence/domicile is simply stated as follows: physical presence in the new State with the simultaneous intent of making it your permanent home and abandonment of the old State of legal residence/domicile.

In most cases, you must actually reside in the new State at the time you form the intent to make it your permanent home. Such intent must be clearly indicated. Your intent to make the new State your permanent home may be indicated by certain actions such as: (1) registering to vote; (2) purchasing residential property or an unimproved residential lot; (3) titling and registering your automobile(s); (4) notifying the State of your previous legal residence/domicile of the change in your State of legal residence/domicile; and (5) preparing a new last will and testament which indicates your new State of legal residence/domicile. Finally, you must comply with the applicable tax laws of the State which is your new legal residence/domicile.

Generally, unless these steps have been taken, it is doubtful that your State of legal residence/domicile has changed. Failure to resolve any doubts as to your State of legal residence/domicile may adversely impact on certain legal privileges which depend on legal residence/domicile including among others, eligibility for resident tuition rates at State universities, eligibility to vote or be a candidate for public office, and eligibility for various welfare benefits. If you have any doubt with regard to your State of legal residence/domicile, you are advised to see your Legal Assistance Officer (JAG Representative) for advice prior to completing this form.

I certify that to the best of my knowledge and belief, I have met all the requirements for legal residence/domicile in the State claimed above and that the information provided is correct.

I understand that the tax authorities of my former State of legal residence/domicile will be notified of this certificate.

SIGNATURE

CURRENT MAILING ADDRESS (Include ZIP Code)

DATE

Form W-4 (2003)

Purpose. Complete Form W-4 so that your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2003 expires February 16, 2004. See **Pub. 505**, Tax Withholding and Estimated Tax.

Note: You cannot claim exemption from withholding if: (a) your income exceeds \$750 and includes more than \$250 of unearned income (e.g., interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized

deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. **However, you may claim fewer (or zero) allowances.**

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See **Pub. 919**, How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the **Instructions for Form 8233** before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2003. See Pub. 919, especially if your earnings exceed \$125,000 (Single) or \$175,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____				
B	Enter "1" if: <table><tr><td>• You are single and have only one job; or</td><td rowspan="3">}</td></tr><tr><td>• You are married, have only one job, and your spouse does not work; or</td></tr><tr><td>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.</td></tr></table>	• You are single and have only one job; or	}	• You are married, have only one job, and your spouse does not work; or	• Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.	B _____
• You are single and have only one job; or	}					
• You are married, have only one job, and your spouse does not work; or						
• Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less.						
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____				
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____				
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____				
F	Enter "1" if you have at least \$1,500 of child or dependent care expenses for which you plan to claim a credit	F _____				
(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)						
G	Child Tax Credit (including additional child tax credit): <ul style="list-style-type: none">• If your total income will be between \$15,000 and \$42,000 (\$20,000 and \$65,000 if married), enter "1" for each eligible child plus 1 additional if you have three to five eligible children or 2 additional if you have six or more eligible children.• If your total income will be between \$42,000 and \$80,000 (\$65,000 and \$115,000 if married), enter "1" if you have one or two eligible children, "2" if you have three eligible children, "3" if you have four eligible children, or "4" if you have five or more eligible children.	G _____				
H	Add lines A through G and enter total here. Note: This may be different from the number of exemptions you claim on your tax return. ►	H _____				
For accuracy, complete all worksheets that apply. <table><tr><td>• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.</td></tr><tr><td>• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$35,000, see the Two-Earner/Two-Job Worksheet on page 2 to avoid having too little tax withheld.</td></tr><tr><td>• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.</td></tr></table>			• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.	• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$35,000, see the Two-Earner/Two-Job Worksheet on page 2 to avoid having too little tax withheld.	• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.	
• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.						
• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$35,000, see the Two-Earner/Two-Job Worksheet on page 2 to avoid having too little tax withheld.						
• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.						

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0010 2003	
► For Privacy Act and Paperwork Reduction Act Notice, see page 2.					
1 Type or print your first name and middle initial		Last name		2 Your social security number	
Home address (number and street or rural route)				3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code				4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. <input type="checkbox"/>	
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)				5	
6 Additional amount, if any, you want withheld from each paycheck				6	\$
7 I claim exemption from withholding for 2003, and I certify that I meet both of the following conditions for exemption: <ul style="list-style-type: none">• Last year I had a right to a refund of all Federal income tax withheld because I had no tax liability and• This year I expect a refund of all Federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ►				7	
Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.					
Employee's signature (Form is not valid unless you sign it.) ►					
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)				9 Office code (optional)	10 Employer identification number

Deductions and Adjustments Worksheet

Note: Use this worksheet **only** if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2003 tax return.

- 1 Enter an estimate of your 2003 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2003, you may have to reduce your itemized deductions if your income is over \$139,500 (\$69,750 if married filing separately). See **Worksheet 3** in Pub. 919 for details.) . . . 1 \$ _____
- 2 Enter: $\left\{ \begin{array}{l} \$7,950 \text{ if married filing jointly or qualifying widow(er)} \\ \$7,000 \text{ if head of household} \\ \$4,750 \text{ if single} \\ \$3,975 \text{ if married filing separately} \end{array} \right\}$ 2 \$ _____
- 3 **Subtract** line 2 from line 1. If line 2 is greater than line 1, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2003 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 \$ _____
- 5 **Add** lines 3 and 4 and enter the total. Include any amount for credits from **Worksheet 7** in Pub. 919 5 \$ _____
- 6 Enter an estimate of your 2003 nonwage income (such as dividends or interest) 6 \$ _____
- 7 **Subtract** line 6 from line 5. Enter the result, but not less than "-0-" 7 \$ _____
- 8 **Divide** the amount on line 7 by \$3,000 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earner/Two-Job Worksheet

Note: Use this worksheet **only** if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
- 2 Find the number in **Table 1** below that applies to the **lowest** paying job and enter it here 2 _____
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3 _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet 4 _____
- 5 Enter the number from line 1 of this worksheet 5 _____
- 6 **Subtract** line 5 from line 4 6 _____
- 7 Find the amount in **Table 2** below that applies to the **highest** paying job and enter it here 7 \$ _____
- 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____
- 9 Divide line 8 by the number of pay periods remaining in 2003. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2002. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1: Two-Earner/Two-Job Worksheet

Married Filing Jointly				All Others			
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above
\$0 - \$4,000	0	44,001 - 50,000	8	\$0 - \$6,000	0	75,001 - 100,000	8
4,001 - 9,000	1	50,001 - 60,000	9	6,001 - 11,000	1	100,001 - 110,000	9
9,001 - 15,000	2	60,001 - 70,000	10	11,001 - 18,000	2	110,001 and over	10
15,001 - 20,000	3	70,001 - 90,000	11	18,001 - 25,000	3		
20,001 - 25,000	4	90,001 - 100,000	12	25,001 - 29,000	4		
25,001 - 33,000	5	100,001 - 115,000	13	29,001 - 40,000	5		
33,001 - 38,000	6	115,001 - 125,000	14	40,001 - 55,000	6		
38,001 - 44,000	7	125,001 and over	15	55,001 - 75,000	7		

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$50,000	\$450	\$0 - \$30,000	\$450
50,001 - 100,000	800	30,001 - 70,000	800
100,001 - 150,000	900	70,001 - 140,000	900
150,001 - 270,000	1,050	140,001 - 300,000	1,050
270,001 and over	1,200	300,001 and over	1,200

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. **Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties.** Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB

control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is: **Recordkeeping**, 46 min.; **Learning about the law or the form**, 13 min.; **Preparing the form**, 59 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. **Do not** send the tax form to this address. Instead, give it to your employer.



TRANSFER INFORMATION SHEET		Date:
Rate:	Name:	SSN:
Command:		

A. INDIVIDUAL CONCERNED COMPLETE SECTION "A" OF THIS FORM AND DELIVER TO YOUR DIVISION OFFICER

Work Phone: ext.	Home Phone: () -	E-mail Address:	
Primary Next Of Kin: Name and Relationship:		Secondary Next Of Kin: Name and Relationship:	
Address:		Address:	
Telephone (including Area Code):		Telephone (including Area Code):	
Requested Transfer Date:			
Requesting Leave (No. of Days):	Leave Address and Phone Number:		
Incur Obligated Service by: <input type="checkbox"/> Extension <input type="checkbox"/> Reenlistment <input type="checkbox"/> Page 13 (if approved)	Advance Pay Desired: <input type="checkbox"/> Yes (Complete attached form) <input type="checkbox"/> No	Advance DLA Desired: <input type="checkbox"/> Yes <input type="checkbox"/> No (married pers. & single E7 & above only)	
Will your dependents accompany you on transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you using your COT entitlement? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	Home of Record:	
Signature of Member:			Date:

B. DIVISION OFFICER complete Section "B" and check the box if task has been completed

<input type="checkbox"/> Indicate Member's Transfer Date if other than requested:
<input type="checkbox"/> Inform individual that transfer departure date will not be changed once it is determined except for emergency reasons, as orders and records will be processed upon return of this form to the Transfers Section.
<input type="checkbox"/> Transfer Information Sheet and required enclosures have been reviewed and verified. PACKAGE MUST BE COMPLETED WITHIN 30 DAYS OF RECEIPT OF ORDERS. <input type="checkbox"/> Copy of PCS Orders <input type="checkbox"/> Request for Advance DLA and/or Dependent Travel Allowance <input type="checkbox"/> Information Pamphlet <input type="checkbox"/> Electronic Funds Transfer form <input type="checkbox"/> PCS Travel Form (NAVPERS 7041/1) <input type="checkbox"/> Temporary Lodging Allowance (TLA) Information Sheet <input type="checkbox"/> Travel Request Form <input type="checkbox"/> Other: _____ <input type="checkbox"/> Application For Transportation of Dependents (DD Form 884) <input type="checkbox"/> Advance Pay Certification/Authorization _____ <input type="checkbox"/> Required obligated service: <input type="checkbox"/> has been completed or <input type="checkbox"/> will be completed on _____. <input type="checkbox"/> Required screening(s) has/have been completed. <input type="checkbox"/> Transfer Evaluation (E6 and below)/FITREP (E7-E9 only) will be forwarded to the Transfers Section at least five (5) working days prior to the transfer date. <input type="checkbox"/> Inform member that check-out procedures will be carried out five (5) working days prior to the transfer date.
I certify that I have taken or initiated action on all items listed in Section "B".
Signature of Division Officer
Date:

C. DEPARTMENT HEAD complete Section "C"

I certify that I have reviewed the above information and recommend: <input type="checkbox"/> Approval <input type="checkbox"/> Disapproval	Date:
Signature of Department Head	

APPLICATION FOR TUITION ASSISTANCE**NAVMC 10883 (REV. 6-97) (EF) (PREVIOUS EDITIONS WILL NOT BE USED.)**

SN: 0109-LF-069-0000

Instructions: Complete and submit form to Navy Campus or Marine Corps Education Center prior to beginning of course. Please print.

SSN :		NAME: LAST		FIRST		MI		
BRANCH OF SERVICE		PAYGRADE		MOS/RATE/RANK/DESIGNATOR		SEX		
DATE OF BIRTH (YYMMDD)		ACTIVE DUTY SERVICE DATE (YY/MM/DD)		END ACTIVE OBLIGATED SERVICE (YY/MM/DD)				
GI BILL ENROLLED IN: 1. Vietnam Era <input type="checkbox"/> 2. VEAP <input type="checkbox"/> 3. MGIB <input type="checkbox"/> 4. EATP <input type="checkbox"/> 5. NONE <input type="checkbox"/>								
WORK PHONE: ()		UIC: (NAVY) (5 DIGITS)		RUC/MCC: (MARINE CORPS) (8 DIGITS)				
COURSE LOCATION								
1. ON-BASE <input type="checkbox"/> 2. OFF-BASE <input type="checkbox"/> 3. DISTANCE LEARNING (I.E., INDEPENDENT STUDY, VIDEO, TV, COMPUTER) <input type="checkbox"/>								
YEARS OF EDUCATION _____								
IMMEDIATE EDUCATION GOAL								
1. HS DIPLOMA <input type="checkbox"/> 2. VOCATIONAL- TECHNICAL <input type="checkbox"/> 3. ASSOCIATE <input type="checkbox"/> 4. BACHELORS <input type="checkbox"/> 5. MASTERS <input type="checkbox"/> 6. DOCTORATE <input type="checkbox"/> 7. PROFESSIONAL (I.E, MD, JD, DDS) <input type="checkbox"/>								
WILL YOU GRADUATE AFTER THIS TERM? YES <input type="checkbox"/> NO <input type="checkbox"/>								
SCHOOL:				DO YOU HAVE A SOCNV/SOCMAR AGREEMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				
TERM START DATE: YY/MM/DD _____				TERM COMPLETION DATE: YY/MM/DD _____				
COURSE INFORMATION								
Course level: H = High School D = Developmental/Prep V = Vocational/Technical L = Lower (Freshman/Sophomore) U = Upper (Junior/Senior) G = Graduate Type of Credits/Hours: S = Semester Q = Quarter C = Clock K = Carnegie (High School)								
COURSE DEPT/ NUMBER		COURSE TITLE		COURSE LEVEL (CODES ABOVE)	NUMBER OF CREDITS/ HOURS	TYPE OF CREDITS/ HOURS	COST PER CREDIT/ HOUR	TOTAL COURSE COST
I request TA with the understanding that I will pay all costs over and above the amount authorized. BY MY SIGNATURE I CERTIFY I HAVE READ, UNDERSTAND AND WILL COMPLY WITH ALL OF THE GOVERNING VOLUNTARY EDUCATION INSTRUCTIONS AND THE PROVISIONS ON BACK OF THIS FORM.								
APPLICANT'S SIGNATURE						DATE		
COMMAND (PRINT)								
COMPLETE ADDRESS								
FAX NUMBER		DSN:		COM:				
APPLICANT'S COMMANDING OFFICER, EXECUTIVE OFFICER, OR OFFICER IN CHARGE: The applicant's present or anticipated military duties will permit him/her to attend and complete the course(s).								
DATE:		TYPED OR PRINTED NAME OF COMMANDING OFFICER			SIGNATURE OF COMMANDING OFFICER			

PRIVACY ACT STATEMENT

Under authority of 5 USC 301 personal data is requested. Your SSN will be used for identification. This information will be included in your Education Record retained by the Education Center. It will not be divulged without your written consent to anyone other than Navy/Marine Corps/school personnel involved with TA. You are not required to provide this information; however, failure to do so will result in not being considered for TA.

AGREEMENT

A. I understand acceptance of TA obligates me to the following:

1. To pay the remainder of tuition cost plus all other costs such as but not limited to textbooks.
2. To submit this application to my servicing Navy Campus or Marine Corps Education Center **prior to beginning of course**. For Navy members, TA will not be authorized after the school's late registration deadline.
3. To personally deliver or mail my TA Authorization Form to the school **during registration**. **If I register for courses prior to receiving a TA Authorization Form, I am liable for the full amount of tuition.**
4. **To notify the Naval Education and Training Professional Development and Technology Center (NETPDTC)* and the Education Center in writing if I do not enroll in any or all course(s) on this form or if I withdraw before the school's "drop/add" date.**
5. To notify NETPDTC* and the Education Center in writing if I enroll in a different course than the one on this form. I can change a course title on the TA Authorization Form only if there is no tuition increase. The new course must apply toward my education goal.
6. To **reimburse**, via money order or cashier's check payable to U.S. Treasury and mailed to NETPDTC*, the tuition paid on my behalf if I:
 - a. **voluntarily withdraw from a course after the "drop/add" date.**
 - b. **receive a failing grade.**
 - c. **fail to clear an incomplete (I) grade within 6 months of course completion date.**
7. To provide NETPDTC*, in the case of an involuntary course withdrawal, a letter from my commanding officer confirming withdrawal was due to hospitalization, PCS, TAD, documented emergency leave or change in military duties or assignment. Reimbursement may be waived if I officially withdrew based on one of these circumstances.
8. To authorize the school I attend to forward a grade report to NETPDTC*. If my school fails to do so, I will be notified by NETPDTC. It then becomes my responsibility to forward my grade to NETPDTC*. **Ultimate responsibility to provide grades to NETPDTC rests with the service member.**

B. I understand the school's failure to provide a grade report or my failure to respond as outlined in paragraphs 1 through 7 will lead to formal resolution/collection efforts such as a letter of indebtedness to my commanding officer and possible pay checkage.

C. I understand I am not entitled to use TA if my grade point average for TA-funded courses falls below a "C" for undergraduate or a "B" for graduate courses.

D. I understand I am not entitled to use TA if receiving other federal financial aid for the same course(s) which results in a duplication of benefits from the U.S. Treasury. I will not apply for/receive VA educational assistance for course(s) on this form.

E. If a Navy Member, I understand I must obtain a Degree Plan or SOCNAV Agreement by the time I have 5 TA-funded courses; only courses required for the degree will be approved for TA.

COMMISSIONED OFFICERS

I agree, in accordance with 10 USC 2007, to remain on active duty for two (2) years after completing the course(s) on this form. This obligation runs concurrently with any remaining obligated service time. This agreement does not obligate the military service to retain me on active duty. If allowed to voluntarily resign before two year obligation is served, I will repay the government a portion of TA expended on my behalf during my last two years of active duty in accordance with 10 USC 2005. Reimbursement of TA does not negate the obligation.

NOTE: All correspondence to NETPDTC should include:

*COMMANDING OFFICER
NETPDTC N8115
6490 SAUFLEY FIELD ROAD
PENSACOLA, FL 32509-5241

- a. Your full name
- b. Your social security number
- c. Name of school and course(s)
- d. Term dates involved
- e. TA document number

WAIVER/REMISSION OF INDEBTEDNESS APPLICATION*(If more space is needed, continue on separate sheet(s). Identify each item by number.)**Form Approved
OMB No. 0730-0009
Expires Sep 30, 2005*

The public reporting burden for this collection of information is estimated to average 2 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0730-0009), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO: Attn: DFAS-POCT/DE, DEFENSE FINANCE AND ACCOUNTING SERVICE - DENVER, 6760 E. IRVINGTON PL., DENVER, CO 80279-7300.

PRIVACY ACT STATEMENT**AUTHORITY:** E.O. 9397 (SSN).**PRINCIPAL PURPOSE:** To be used by civilian employees (current, former, or retired) and military members (active, separated, or retired) to request waiver of indebtedness collection for erroneous payments of salary or pay and allowances, and expense reimbursement or allowances for travel, transportation, and relocation; or in the case of enlisted members, remission of these debts.**ROUTINE USE(S):** In addition to those disclosures generally permitted under 5 U.S.C. Section 552a of the PA, this information may be disclosed to the Department of Justice or to commercial credit agencies, whenever a financial status report is requested by the Department of Defense (DoD) for use in administering the Federal Claims Collection Act. It may also be disclosed for any of the blanket routine uses as published in the Federal Register at the beginning of the DFAS compilation of PA system notices.**DISCLOSURE:** Disclosure is voluntary; however, failure to disclose the requested data, including your Social Security Number, may prevent consideration of the claim.**1. TYPE OF CLAIM** (*X one*) ☐ **WAIVER** ☐ **REMISSION**

Authority for granting waiver is 5 U.S.C. 5584, 10 U.S.C. 2774, or 32 U.S.C. 716. Authority for granting remission is 10 U.S.C. 4837, 10 U.S.C. 6161, or 10 U.S.C. 9837. **NOTE:** Remission generally for active duty enlisted only; see DoD FMR, Volume 7A, Chapter 50, for specifics on who may apply.

SECTION I - CIVILIAN/MILITARY INFORMATION**2. NAME** (*Last, First, Middle Initial*) **3. RANK/GRADE** **4. SOCIAL SECURITY NUMBER****5. AGENCY/SERVICE**☐ **ARMY** ☐ **OTHER** (*Specify*)☐ **NAVY**☐ **AIR FORCE**☐ **MARINE CORPS****6. STATUS** (*Provide date (YYYYMMDD) for end of enlistment period (EOE), retirement (DOR), separation (DOS), or service computation date (SCD), as appropriate.*)☐ **ACTIVE**

EOE: _____

☐ **SEPARATED**

DOS: _____

☐ **GUARD/RESERVE**

EOE: _____

☐ **DOD CIVILIAN**

SCD: _____

☐ **RETIRED**

DOR: _____

7. CURRENT COMPLETE MAILING ADDRESS (*Street, City, State, ZIP Code*)**8. PLACE OF ASSIGNMENT OR EMPLOYMENT****9. TELEPHONE** (*Include DSN or area code*)**a. WORK****b. HOME****c. E-MAIL ADDRESS:****10. TYPE OF DEBT OR PAY AND ALLOWANCE ERRONEOUSLY PAID****11. GROSS DEBT AMOUNT****12. STATE THE DATE AND HOW YOU FIRST BECAME AWARE OF DEBT OR ERRONEOUS PAYMENT.** (*Attach notification, if available.*)**13. IF YOU WERE AWARE OF DEBT OR ERRONEOUS PAYMENT, EXPLAIN THE ACTIONS YOU TOOK TO CORRECT SITUATION.****14. REASON FOR REQUESTING WAIVER/REMISSION AND WHY YOU FEEL IT SHOULD BE APPROVED** (*Financial hardship applies ONLY to REMISSION and if claimed, a financial statement must be attached.*)**15. DID YOU RECEIVE AND REVIEW YOUR LEAVE AND EARNINGS STATEMENT(S) OR DID YOU REQUEST THEM ON EMSS?**☐ **YES** (*Attach one LES each for before, during, and after the debt period involved.*) ☐ **NO** (*Explain*)**16. ATTACH COPIES OF ALL PERTINENT DOCUMENTS** (*Such as Request for BAH, Statement of Service, Separation Worksheet, DD Form 214, Travel Voucher, Notification of Personnel Action.*) (*If not available, please explain.*)**17. HAVE YOU FILED FOR A CORRECTION OF MILITARY RECORDS?**☐ **YES**☐ **NO****18. I certify the above statements are true and correct to the best of my knowledge. The information presented may be referred to the appropriate investigating office for verification. I understand the penalty for a false claim is a maximum fine of \$10,000 or a maximum imprisonment of 5 years, or both.****a. SIGNATURE****b. JOB TITLE/CAREER FIELD****c. DATE SIGNED**

19. COMMANDER'S ENDORSEMENT <i>(Required for Navy active duty and reserves, others optional. Use separate sheet of paper if needed.)</i>														
20. RECOMMENDATION:	<input type="checkbox"/> APPROVE	<input type="checkbox"/> PARTIAL \$	<input type="checkbox"/> DENY	RECOMMEND COLLECTION RATE \$										
21a. COMMANDER'S SIGNATURE			b. DATE SIGNED											
SECTION II - REPORT OF INVESTIGATION <i>To be completed and signed by appropriate payroll/travel office. (Not applicable for out-of-service military members.)</i>														
22. INFORMATION ON DEBT OR ERRONEOUS PAYMENT(S)														
a. GROSS DEBT AMOUNT		b. TYPE(S) OF PAYMENT(S)		c. DATE(S) OF PAYMENT(S)										
d. <i>(X and complete as applicable)</i>		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 30px;">YES</td> <td style="width: 30px;">NO</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		YES	NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(5) DATE THE DEBT WAS DISCOVERED
YES	NO													
<input type="checkbox"/>	<input type="checkbox"/>													
<input type="checkbox"/>	<input type="checkbox"/>													
<input type="checkbox"/>	<input type="checkbox"/>													
<input type="checkbox"/>	<input type="checkbox"/>													
(1) HAS THE DEBT BEEN VALIDATED?				(6) NAVY ONLY: AMOUNT UNCOLLECTED AS OF DATE OF THE COMMANDER'S SIGNATURE: \$										
(2) HAS THE DEBT BEEN POSTED TO THE DEBTOR'S RECORDS?														
(3) REMISSION: HAS THE COLLECTION ACTION BEEN SUSPENDED?														
(4) WAIVER: HAS FINANCE OFFICE SUSPENDED COLLECTION IAW DODFMR, VOL. 5, CH. 31?														
23. A DEBT COMPUTATION MUST ACCOMPANY THIS APPLICATION. It must include dates of erroneous payments, what was paid (broken down by entitlements), what should have been paid, and the difference. The total debt must equal the debt posted to the debtor's record. Indicate any entitlements or credits used to offset the debt. This application will be returned without action unless the computation is included.														
a. ENTITLEMENT	b. DATE(S)	c. WAS PAID	d. SHOULD HAVE BEEN PAID	e. DIFFERENCE										
24. DETAILED STATEMENT OF HOW AND WHY ERROR OCCURRED.														
25. IS THERE ANY INDICATION OF FRAUD, MISREPRESENTATION, FAULT, OR LACK OF GOOD FAITH ON THE PART OF THE CLAIMANT? <input type="checkbox"/> YES <i>(Explain)</i> <input type="checkbox"/> NO														
26. STATEMENT AS TO WHETHER OR NOT THE CLAIMANT KNEW OR SHOULD HAVE BEEN AWARE OF RECEIVING AN ERRONEOUS PAYMENT. <i>(Furnish facts and circumstances to support answer, state whether claimant received documents, and provide copies, if available. Use a separate sheet of paper if additional space is required.)</i>														
27. REMARKS <i>(Attach a separate sheet of paper, if needed.)</i>														
28. RECOMMENDATION:		<input type="checkbox"/> APPROVE		<input type="checkbox"/> PARTIAL \$										
				<input type="checkbox"/> DENY										
29. DESIGNATED FINANCIAL AGENT														
a. SIGNATURE		b. TITLE		c. DATE SIGNED										
30a. COMPLETE UNIT MAILING ADDRESS		b. POINT OF CONTACT NAME												
		c. TELEPHONE <i>(DSN)</i>		d. FAX NUMBER										
e. ADSN/DSSN/UIC		f. E-MAIL ADDRESS												

MEDICAL SCREENING CERTIFICATION

NAME: _____ SSN: _____

COMMAND: _____ UIC: _____

Date of exam: _____

Medical Officer: _____

Clinic: _____

Fit for Duty Determination: In accordance with MILPERSMAN 1160-040 and
MANMED 15-50, above named member
(is / is not) medically qualified to continue service.

Female ordered to Type 2: above named member (is / is not) pregnant.

(Signature of Medical Officer)